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DOI:

[10.1080/09687637.2016.1235135](https://doi.org/10.1080/09687637.2016.1235135)

*Document Version*

Peer reviewed version

[Link to publication record in King's Research Portal](#)

*Citation for published version (APA):*

Tompkins, C. N. E., & Neale, J. (2016). Delivering trauma-informed treatment in a women-only residential rehabilitation service: Qualitative study. *Drugs: Education, Prevention and Policy*, 1-9.  
<https://doi.org/10.1080/09687637.2016.1235135>

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**DELIVERING TRAUMA-INFORMED TREATMENT IN A WOMEN-ONLY RESIDENTIAL  
REHABILITATION SERVICE: QUALITATIVE STUDY**

**Dr Charlotte N. E. Tompkins<sup>a</sup> & Dr Joanne Neale<sup>a,b</sup>**

<sup>a</sup> National Addiction Centre, Institute of Psychiatry, Psychology & Neuroscience, King's College London, Addictions Sciences Building, 4 Windsor Walk, Denmark Hill, London, SE5 8BB. ENGLAND.

<sup>b</sup> Centre for Social Research in Health, University of New South Wales, Sydney, AUSTRALIA.

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**Corresponding author**

**Dr Charlotte N. E. Tompkins**

National Addiction Centre

Institute of Psychiatry, Psychology & Neuroscience, King's College London

Addictions Sciences Building

4 Windsor Walk

Denmark Hill

London, SE5 8BB. ENGLAND

0207 848 0257

[charlotte.tompkins@kcl.ac.uk](mailto:charlotte.tompkins@kcl.ac.uk)

# DELIVERING TRAUMA-INFORMED TREATMENT IN A WOMEN-ONLY RESIDENTIAL REHABILITATION SERVICE: QUALITATIVE STUDY

## ABSTRACT

**Aim:** This paper explores the delivery of trauma-informed residential treatment, focusing on factors that affect how it is provided by staff and received by clients, particularly the challenges encountered.

**Methods:** Semi-structured qualitative interviews were conducted with stakeholders (n=3), staff (n=15), and clients (n=19) of a women-only trauma-informed residential rehabilitation service in the United Kingdom. Interview data were systematically coded and analysed using Iterative Categorisation.

**Findings:** Trauma-informed treatment delivery was affected by: 'recruiting and retaining a stable and trained staff team'; 'developing therapeutic relationships and working with clients'; and 'creating and maintaining a safe and stable residential treatment environment'. Clients' complex needs and programme intensity made trauma-informed working demanding for staff to deliver and for clients to receive. Staff working in the residential service needed sufficient training, support, and supervision to work with clients and keep themselves safe. Clients required safety and stability to build trusting relationships with staff and engage with the treatment.

**Conclusions:** Trauma-informed residential treatment seems a valuable way of working with women with co-occurring substance use and trauma. However, it is challenging to deliver and likely to require significant resource investment. These findings appear relevant given increasing international interest in trauma-informed approaches within the addictions.

**Keywords:** substance use, substance use treatment, trauma, trauma-informed, women, qualitative.

# **DELIVERING TRAUMA-INFORMED TREATMENT IN A WOMEN-ONLY RESIDENTIAL REHABILITATION SERVICE: QUALITATIVE STUDY**

## **INTRODUCTION**

Trauma is defined as 'exposure to actual or threatened death, serious injury or sexual violation' (American Psychiatric Association, 2013). Ongoing exposure to abuse, committed by one human being against another, may result in complex trauma (Covington, 2008). The effects of trauma can severely disrupt and negatively shape an individual's behaviours, their ability to function, and their perceptions of themselves and others, especially when the perpetrator is a family member or is personally known (Bateman, Henderson & Kezelman, 2013). Trauma during childhood can hinder psychological development and significantly increase the risk of physical and mental health issues and post-traumatic stress disorder (PTSD) in adulthood (Felitti et al., 1998; Jonas et al., 2011). It can also escalate vulnerability to drink or drug addiction, often as way of coping (Covington, 2008; Fallot & Harris, 2002; Jonas et al., 2011; Najavits, 2009).

Research has consistently shown that women experience more physical and sexual abuse than men, including disproportionate abuse by male intimate partners (Bebbington et al., 2011; Khalifeh et al., 2013; NICE, 2014; Radford et al., 2013). The relationship between trauma, abuse, gender, and substance use is also well-established, with known high levels of physical and sexual abuse and trauma amongst female drug and alcohol users (Greenfield et al., 2007; Hammersley et al., 2016; McKeganey, Neale & Robertson, 2005; Najavits, 2009; Najavits, Weiss & Shaw 1997). Reflecting this, a key development in addiction treatment in the United States (US) over the last two decades has been the expansion of trauma-informed treatment - a gender-specific approach that aims to facilitate long-term recovery from both addiction and trauma simultaneously (Brown, Harris & Fallot, 2013; Elliott et al., 2005; Finkelstein et al., 2004).

According to Harris and Fallot (2001), trauma-informed services: i) take trauma into account, ii) avoid triggering trauma reactions or re-traumatising people, iii) adjust the behaviour of staff to support individuals to cope, and iv) allow survivors to manage their trauma symptoms successfully. Safety, trustworthiness, collaboration, choice, and empowerment have been identified as the five core values of trauma-informed programmes (Fallot & Harris, 2009; Harris & Fallot, 2001; Harris & Fallot, 2004). Operating principles include providing clear information to clients, being consistent in practice, engaging in mutual decision making with clients, and adopting holistic approaches within a physically safe and calm therapeutic environment (Bateman, Henderson & Kezelman, 2013; Brown, Harris & Fallot, 2013; Elliott et al., 2005; Fallot & Harris, 2009; Harris & Fallot, 2001; Harris & Fallot, 2004; Herman, 1992). It is also recommended that staff delivering trauma-specific interventions receive in-depth education and training about trauma (Brown, Harris & Fallot, 2013; Fallot & Harris, 2009; Harris & Fallot, 2004) and ongoing support from trauma-informed supervisors (Elliott et al., 2005).

Trauma-informed working is based on the assumption that all addiction treatment clients have experienced some form of trauma, so the approach focuses on their personal strengths to avoid disempowering them further or re-traumatising them (Covington, 2008; Elliott et al., 2005; Killeen, Back & Brady, 2015). As part of this process, staff help clients to address their needs and feel safe, educate clients about trauma and its impact, and enable clients to identify potential triggers and cues which remind them of their trauma. Staff also teach clients coping and self-soothing techniques to use if they involuntarily re-experience the trauma (Brown, Harris & Fallot, 2013; Covington, 2008). Trauma-informed working can draw upon a range of integrated treatment programmes such as the Trauma, Recovery and Empowerment Model (Harris, 1998), Seeking Safety (Najavits, 2002) and Helping Women Recover (Covington, 1999). Trauma-specific psychotherapy treatments may also be used, such as Eye Movement Desensitization and Reprocessing (EMDR), which aims to reduce the long-lasting effects of distressing memories by developing more adaptive coping mechanisms (NICE, 2005).

Advocates argue that trauma-informed treatment helps to address women's needs, increase stays in treatment, and reduce the risk of trauma-based relapse (Brown Harris & Fallot, 2013; Covington, 2008; Dass-Brailsford & Myrick, 2010; Elliott et al., 2005; Finkelstein et al., 2004). Additionally, quantitative research, predominantly from the US, has identified small but statistically significant clinical improvements in depression, trauma symptomatology, and substance use severity amongst women receiving trauma-specific treatment for concurrent trauma and substance use disorders (Cocozza et al., 2005; Covington et al., 2008; Morrissey et al., 2005). Despite this, some uncertainty regarding effectiveness remains, with systematic reviews suggesting a lack of clear evidence for the superiority of integrated trauma-informed and addiction treatment over non-integrated programmes (due to small sample sizes and methodological issues with the included studies) (Torchalla et al., 2012; van Dam et al., 2012). There is also a lack of qualitative research exploring the day-to-day delivery of trauma-informed substance use treatment (Dass-Brailsford & Myrick, 2010; Drabble, Jones & Brown, 2013; Morrissey et al., 2005).

Using an in-depth case study approach, this paper aims to address some of these gaps in knowledge by exploring factors that affect the delivery of trauma-informed treatment in one women-only residential rehabilitation service based in the United Kingdom (UK). In particular, we seek to identify any challenges experienced by staff (in delivering the programme) and clients (in receiving the programme). In the UK, current practice guidance is to treat drug dependence before PTSD (NICE, 2005) and trauma-informed working is rarely practised. However, the link between trauma and drug dependence is formally acknowledged in drug policy (HM Government, 2010) and there is increasing interest in trauma-informed drug treatment services (Hammersley et al., 2016; Scottish Drugs Forum, Hammersley & Dalgarno, 2013). This interest also extends to female prisons (Covington, 2015). Our findings may therefore provide useful insights for those considering trauma-informed working in the UK, and potentially beyond.

## METHODS

### Setting

The study was conducted within an abstinence-based organisation for men and women overcoming substance use. As part of its offer to clients, the service had a women-only residential service which operated a trauma-informed approach to treatment. It also had mixed-sex services, although these were not based on trauma-informed working. Data collection for the study focused on the women-only residential treatment service.

The residential service treated up to ten women at any one time and was staffed twenty-four hours a day, seven days a week, by at least seven permanent female staff. Staff were all trained in trauma-informed approaches and received regular professional support and supervision from within the organisation. Every month, they also received team support and supervision from an experienced trauma therapist who was external to the organisation. All potential residential clients were screened for trauma on referral. Once at the service, clients participated in a range of group therapies based on manualised trauma-informed treatment programmes. They were also offered individual counselling, EMDR, and family support according to their specific needs, had access to a structured programme of education skills, training, and recreational activities, and attended local fellowship meetings (Narcotics Anonymous and Alcoholics Anonymous).

On a day-to-day basis, the residential service operated like a home, with the women living there being responsible for cooking, cleaning, and domestic duties. The atmosphere was intended to be relaxed and sociable, and abstinence was required as part of the therapeutic contract. Clients were initially funded to stay for twelve weeks, though many received additional funding for a further twelve weeks. After successfully completing treatment, the women moved into their own accommodation or into one of the organisation's resettlement

houses. They could, however, still receive on-going support from the women-only service and wider organisation, especially if they stayed within the local area.

#### Data collection

Ethical approval for the research was obtained from a University Ethics Committee. Following approval, 37 semi-structured interviews were conducted between April and August 2015. A range of participants were purposively sampled to encompass those likely to have varying experiences of the trauma-informed treatment. They included: 3 key stakeholders who had established the trauma-informed service; 15 staff (7 current trauma-informed service staff, 3 former trauma-informed service staff, and 5 staff working elsewhere in the organisation); and 19 clients of the trauma-informed service (9 current clients, 5 former clients who had successfully completed treatment, and 5 former clients who had left the service prematurely).

Two experienced qualitative researchers (CB and CT) approached potential participants and provided them with written and verbal information about the study. Those who expressed interest were invited to interview. Prior to the start of the interview, the researchers assured participants of their anonymity and took written informed consent. Interviews were then conducted in private (either in the residential service or in a neutral venue elsewhere for former service clients). All interviews followed a topic guide that explored participants' personal circumstances and views and experiences of the trauma-informed approach (positive and negative features, perceived effectiveness, and suggestions for improvement). Staff were also asked to provide information on their experiences of delivering the trauma-informed programme, whilst clients were asked about their experiences of receiving it. All interviews were audio-recorded and transcribed verbatim by a professional transcriber. Stakeholder and staff interviews lasted between 51 and 116 minutes; client interviews lasted 35 to 104 minutes. Staff received no compensation for taking part; clients received a £10 high street gift card to thank them for their time.



## Data management and analysis

A systematic and transparent technique known as Iterative Categorisation (IC) guided the data management and analysis process (Neale, 2016). First, CT read a selection of stakeholder and staff interview transcripts and made notes on key issues discussed. CT then used these notes to develop a coding system that comprised deductive codes (derived from the topic guides) and inductive codes (emerging from the interview data). This was to ensure that all data were captured. The coding system contained both substantive codes (such as 'staff background,' 'rehab programme,' and 'rehab life') and more specific sub codes (such as 'working with clients as individuals,' and 'working as a team'). Once complete, CT repeated the process with the client interviews, thus generating a separate, but not dissimilar, coding system.

Next, the two separate coding systems were entered into the qualitative software programme MaxQDA (v11), and all the interview transcripts were imported. CT then systematically coded the transcripts in MaxQDA, assigning sections of text to the relevant codes in the appropriate coding system until all the data were assigned. For the present paper, codes relating to the delivery and receipt of the trauma-informed treatment were analysed. In line with IC, the raw data from these two codes were exported from MaxQDA into a new Microsoft Word document (Neale, 2016). CT then reviewed the Word files line-by-line, identified key points within the coded data, and summarised these. During this process, CT grouped and merged issues until the findings had a logical and clear thematic structure.

Once all the data had been summarised and ordered, the authors revisited them to identify patterns and explanations, with a particular focus on any factors that challenged trauma-informed working. During this stage, similarities and differences within and between the different participant groups were explored. The analyses and emerging findings were refined on several occasions following discussions between the authors, discussions with two of the

key stakeholders, and peer review. First, we present some contextual information about the interview participants, and then we report the findings.

## Participants

All stakeholders and staff had worked within the organisation for between 4 months and 17 years, and 11 reported a personal history of substance use. The mean length of time the current trauma-informed service staff had worked in the women-only residential service was 32 months. Clients were aged between 25 and 44 years and all but 3 were White British. Their substance use histories ranged from 2 to 25 years; 7 were in treatment for Class A drug use, 7 for alcohol use, and 5 for combined Class A drug and alcohol use. Seven clients said that they had sex worked and 4 had been in prison. Most were mothers, whose children were currently living with family members or in local authority care.

As children, clients collectively reported that they had felt unloved, neglected or abandoned, had been brought up in care, had been bullied at school, had witnessed and experienced domestic violence, had been bereaved by close family members, and had been sexually abused by men. Many also reported exposure to problem drinking and drug use by parents, siblings or wider family members. As adults, they described physical, emotional, and sexual abuse by intimate partners and/ or strangers, bereavements, self-harm, eating disorders, suicide attempts, and residential psychiatric treatment. Self-reported trauma symptoms included recurrent and intrusive images, flashbacks, nightmares, being easily startled, bed wetting, and intense feelings when reminded of their trauma. They also discussed memory or concentration problems, repressed or dissociated emotions, and feeling generally 'uninterested' or 'numb'.

## FINDINGS

Our analyses revealed that treatment delivery was affected by three key factors: 'recruiting and retaining a stable and trained staff team'; 'developing therapeutic relationships and working with clients'; and 'creating and maintaining a safe and stable residential treatment environment'. We also identified cross-cutting issues that challenged treatment delivery. To illustrate key findings we use anonymised quotations.

### **Recruiting and retaining a stable and trained staff team**

Stakeholders and staff agreed that the trauma-informed service needed a high ratio of staff to clients to deliver the programme since clients' difficult trauma histories demanded extensive staff attention and support. When recruiting new staff, stakeholders and staff who had a management role emphasised that it was important to consider each candidate's experience and background and how that fitted with the diverse and complex needs of the clients. Managerial staff felt that service workers should be female and have a particular mixture of personal qualities, experiences, and skills in order to be able to work effectively with the clients. They actively recruited women who had direct personal experience of recovery and women with prior experience of working with women and/ or substance users. To this end, managers sought to recruit staff whom they considered to be compassionate, understanding, nurturing, dedicated, self-disciplined, and assertive:

*It's not about being all lovey-dovey and, you know, 'there-there-there'. That's not what we want. We need women that are assertive, that are boundaried, so they can say, 'No, that's not alright', but they can deliver that in a sensitive and respectful way, [so] that the woman is able to hear and still feel valued. (Staff #8)*

According to stakeholders and staff, the nature, needs, and experiences of the female clients all living and receiving treatment together created a challenging working environment. In consequence, they stressed that trauma-informed staff needed to know how to maintain their personal and professional boundaries in order to protect their own well-being and be

consistent in their approach towards clients. Reflecting this, all staff described various strategies for taking care of themselves when working in the service, including keeping to their working hours and taking breaks during the day. Outside of work, staff in recovery also said that they practised mindfulness or attended mutual aid groups to help maintain their recovery and protect their own emotional welfare:

*I have to put a lot into my own recovery and away from this area as well... My [mutual aid] meetings are where no clients attend, so I can continue to get my own support... If I'm not OK in my recovery, a lot of the stuff that the women are doing will land and I'm less able to be effective in my role. (Staff #3)*

Given the lack of trauma-informed services across the UK, it was not surprising that staff reported that they had had no prior skills in, or experience of, trauma-informed working before being employed at the service. They therefore described feeling initially unclear about what trauma-informed working entailed and referred to needing to 'learn on the job', with support from more experienced colleagues. In this regard, close team working, including monthly mentoring and supervision, were identified as helping them to develop the necessary confidence and skills to use trauma-informed techniques and to reflect on their practice:

*Not having years of experience working in the services myself, it's blown me away a bit. On occasions I've been like, 'Whoa, I don't know what to do with this. Do you know? Hands up, team. Help!' Certainly, that's put a bit of fear in me, really. How can I help this client when I don't know what I'm talking about? (Staff #2)*

Since stakeholders and staff believed that staff needed to be comprehensively trained in the delivery and use of trauma-informed approaches, the organisation had recently commissioned two days of intensive trauma-informed staff training from the US author of a

manualised trauma treatment programme. Staff universally reported that the bespoke training had helped them to consider how to deliver the manualised treatment programme, facilitate treatment groups, work with clients in ways that took existing trauma histories into account, and learn how to 'soothe' and 'ground' clients if they had a trauma response. They acknowledged that it had also provided them with the chance to reflect on their individual and team working practices, including the need to protect their own emotional health in order to be effective in their roles.

Despite the above benefits, the training had limitations. Staff who had been trained still reported that it had taken time for them to feel competent and confident in using the trauma-informed approach. Meanwhile, new staff, who had been employed after the training, and relief staff, who were temporarily employed in the service, had not been trained. Consequently, they reported that they still lacked crucial knowledge, confidence, and familiarity with trauma-informed approaches:

*I would definitely like to get trained in [trauma-informed working]... I didn't know what hit me when I went in there. It's very different to in here [non-trauma-informed service], like just in the way that you work. (Staff #7)*

Further undermining the organisation's efforts to maintain an appropriately qualified stable and trained team, stakeholders and staff noted that employees would not work in the service indefinitely and they could need time off in the event of illness. Equally, stakeholders and staff often stated that a real challenge of trauma-informed working was that staff could become too emotionally or personally involved with clients or affected by the clients' experiences, which could undermine their own wellbeing and ability to deliver the trauma-informed programme:

*I did, at the beginning, find the groups a bit difficult. I found it quite emotional. I was*

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*taking on the feelings a bit too much, come away [feeling] really heavy after work.*

*(Staff #1)*

Reflecting this, one worker who was not in recovery from drug or alcohol misuse, reported that she had recently been reminded of her own trauma. She had had a physiological and emotional trauma response, and had required counselling and time away from the service. Stakeholders and staff noted that absences and job vacancies could risk treatment delivery and potentially undermine its success, especially if relief staff were used to provide cover. During times of staff shortages, the workloads of current staff also increased and this could cause them to feel stretched across their responsibilities, which in turn undermined the quality of their work and increased their propensity to stress and burnout:

*I feel like we're really stretched and actually the quality is being stretched... The quality is still there, but it's thinning, if you know what I mean. (Staff #15)*

### **Developing therapeutic relationships and working with clients**

Stakeholders, staff and clients all believed that the therapeutic relationships between clients and staff were at the heart of how the trauma-informed approach worked. Staff explained that developing good trauma-informed therapeutic relationships with individual clients involved not judging clients, never giving up on them, treating them differently from how they were accustomed to being treated, and identifying what motivated them. It also meant working collaboratively with clients to ensure that each individual's needs were fully understood and treatment care plans were tailored with the woman at the centre.

Staff also stated that supporting women in a trauma-informed way and building a relationship with them required workers to be available, flexible, consistent, nurturing, honest, and to show clients that they genuinely cared about them. Despite this, they recognised that members of staff should not be overprotective as this could encourage clients to become

dependent on them:

*We take a very nurturing approach to these women... Sometimes you have to challenge their behaviour, of course, absolutely, but telling people who think they're worthless off just reaffirms the belief, you know? If you challenge from a place of love and show them a different way, the results are far better. (Staff #3)*

Staff reported that it was easier to develop therapeutic relationships with women who were fully detoxed, used to attending treatment groups, determined to stop using substances, and curious about exploring their trauma experiences alongside their addiction. Staff maintained that this was because women who presented as more stable had fewer immediate needs to address, and were typically more prepared for treatment than others. Clients tended to concur with these views:

*I really loved it, but I think that's because I was ready... If you're not ready and you try and push it... I think it could probably be hell. I was ready because I'd lost everything... I think if you want to and you're willing to learn, it's really interesting. (Client #2)*

In addition, staff felt that strong therapeutic relationships were underpinned by an unfailing belief that women could recover from addiction and trauma. This belief helped women to trust staff and also enabled them to start to believe in their own ability to recover. In this regard, staff who had personal experiences of addiction and recovery maintained that they were particularly able to empathise with, and guide, clients. Clients also placed considerable significance on the addiction experiences of staff. Thus, they reported feeling understood by staff who had 'been there' and inspired by them that recovery was achievable:

*Having staff in recovery as well, that's a big eye-opener really. [It helps] because it*

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*shows that, you know, addicts do recover, and can lead normal lives... And they know all the traits, all our behaviours, you know. So they see it before we even know it's coming. (Client #14)*

In contrast, staff reported that clients with little interest in ceasing their substance use or understanding their trauma, or who attended the service purely to fulfil the requirements of a court order or to appease family members, were less susceptible to developing therapeutic relationships and were less well prepared for treatment. Staff recognised, however, that being prepared for treatment did not guarantee successful therapeutic relationships or lead to successful engagement with the trauma-informed programme since there were many other factors (most notably distracting romantic relationships with men outside the service) that influenced clients' motivation and could potentially undermine delivery of the programme.

Significantly, most current and former clients said that they had not known that the service was guided by a trauma-informed approach and had not realised what the treatment involved before arriving at the service. Consequently, they had not anticipated that they would have to learn about trauma, talk about their feelings, develop therapeutic relationships, or reflect on their past experiences and behaviours:

*I was just resistant. I didn't want to touch on any of the issues that I had around abuse, around the reasons why I was in the women's house, the abuse and sex working etcetera. I just distracted. I... couldn't deal with it. I wasn't ready. (Client #20)*

Clients explained that their previous experiences of trauma and abuse and their lack of familiarity in opening up and sharing their experiences undermined their ability to trust people, which in turn had affected their relationships with staff. Indeed, on arriving at the service, clients commonly reported feeling unstable, afraid, alone, and suspicious of



everyone, including staff. Moreover, some reported that, even as treatment progressed, they continued to struggle to trust staff fully, be honest with them or develop relationships with them; instead, they said that they acted defensively or vigilantly to protect themselves from being hurt or betrayed:

*[At first] I avoided her because I knew she was my worker. But then I put a bit of trust in her, and I would seek her out. I would go and speak to her... I wasn't always a hundred percent honest with her, but I was more honest with her than I was anyone else. (Client #8)*

Former clients who had left the service early also often reported that they had not engaged with the treatment or developed therapeutic relationships with the staff as they had not wanted, or felt able, to consider their past experiences of trauma. Meanwhile, clients who had engaged positively with the treatment and had developed relationships with the staff stated that, over time, it had helped them to slowly reflect on, and understand themselves, their past feelings, their behaviours, and to start to contemplate their recovery. These clients also confirmed that feeling genuinely cared for by staff who were dedicated and approachable helped them to begin to trust staff and develop relationships with them:

*They're [staff are] gentle, they're loving, they're firm, they make us laugh, they're knowledgeable. You just feel, I just feel understood, I feel held, I'd feel loved, I feel like I can trust, trust them and feel like they really care. (Client #1)*

### **Creating and maintaining a safe and stable residential treatment environment**

Stakeholders, staff and clients all emphasised that residential service clients needed to feel physically and emotionally safe during treatment if they were to engage in trauma-informed treatment and to benefit from it. Consequently, staff prioritised client safety, particularly at the start of their treatment:

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*Whether it's a group, or a lecture, or an activity, safety is paramount... because their world before was so unsafe and so untrusting, and they're always looking for, is this safe...? Because, if they don't feel safe, they won't trust and they won't participate.*

*(Staff #15)*

According to staff, safety was underpinned by organisational policies, such as forbidding women from having visitors in the house. Staff also believed that safety and stability were enhanced by the set daily routine and structured timetable of activities that were part of the treatment programme:

*One of the main things that provide safety in [the service] is structure, that's one of the main things. And a lot of women really struggle because they don't understand that in the beginning, and then they start to become familiar with it, and then they start to rely on it. (Staff #9)*

Staff additionally stated that client safety was promoted when trauma-informed treatment groups were held in spacious (rather than small) rooms. This, they said, was because larger rooms reduced the likelihood of women feeling claustrophobic if their feelings intensified during a group. Staff similarly advocated the use of rooms inside the familiarity of the women-only service, noting that other venues within the organisation were frequented by clients from the mixed-sex residential treatment services and this discouraged women from 'opening up'. Indeed, staff maintained that women felt more comfortable, secure and therefore likely to share their experiences when they were familiar with, and in control of, their surroundings. Reflecting this, some staff highlighted how the recent building of a new group treatment room within the grounds of the women-only service seemed to have increased women's sense of safety and treatment engagement:

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*I've noticed... a massive change actually, just with the level of disclosure. And also the time new people take to say they feel safe. Our newer admissions are starting to feel safe much quicker. Whereas before they would go to the education centre, there's all guys and hustle and bustle and they wouldn't feel, necessarily feel, as safe as quickly. (Staff #3)*

Staff and clients both reported that the demands of residential trauma-informed treatment, particularly living amongst other women and participating in treatment groups, could distress and unsettle clients, especially when they were new to the service and had yet to learn how to regulate their emotions and responses. Indeed, it was generally accepted that the experience could re-trigger clients' trauma or their desire to use substances, potentially unsettling other clients. More generally, staff acknowledged that the women-only service was highly changeable and unpredictable, due to client disputes, client relapses, or women not getting on with one another. They explained that because women lived and received treatment under the same roof, their feelings and behaviours frequently spilled between treatment and daily living. Furthermore, unexpected noises or actions, such as raised voices or slamming doors, could remind clients of their previous experiences of trauma and abuse. Staff therefore reported being permanently mindful of the volatility of the residential treatment environment and understood that they had to react quickly to calm any clients who became unsettled or felt unsafe:

*We don't know where or how or when a woman's trauma is going to be triggered... All of a sudden, just like that, she's going to have a huge feelings change. So she's going to become overcome with a different feeling to what she had a second before. She's going to think in a generally in a more panicky way, in a quicker way, in a more anxious way. So her thoughts will speed up, she might all of a sudden go from feeling completely relaxed to feeling hugely unsafe. (Staff #12)*

For their part, clients reported that getting on with other women in treatment, being in a drug-free women-only residential environment with a homely atmosphere, and having close relationships with staff who were caring, professional and available around the clock were central aspects of feeling secure in the service:

*You feel safe and secure, you know, and you knew that somebody was there 24/7 to support you, in case something is going on, you know, with the feelings and emotions. (Client #21)*

Clients also explained that the structured daily routine and treatment timetable reinforced their sense of safety and contrasted with the insecurity and unpredictability of their pre-treatment lives:

*You come here and all of a sudden you've got three meals a day and you wake up and you do this and your day is set out, you have a timetable, you get given a timetable, and that's completely different from the life that I had... coming here and being like, 'this is what's going to happen' is really nice. And I didn't really realise it at the time, but in hindsight that's ridiculously comforting, it's so needed. (Client #8)*

## **DISCUSSION**

Our study has focussed on the delivery of trauma-informed treatment in one women-only residential rehabilitation service based in the UK. Consistent with previous research, we found that women attending the service reported emotional, physical, and sexual abuse (both as children and adults), lengthy substance using histories, experiences of sex work, imprisonment, and complex psychosocial problems, including compromised family and personal support networks (Hammersley et al., 2016; McKeganey, Neale & Robertson, 2005). These findings point to the need for carefully designed interventions delivered by trained professionals

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specifically tailored for this population. Trauma-informed residential treatment, with its emphasis on manualised treatment programmes and trauma-specific psychotherapies, appears to offer a valuable approach; yet it is not a simple panacea.

Our analyses indicated that treatment delivery was affected by three key factors: 'recruiting and retaining a stable and trained staff team'; 'developing therapeutic relationships and working with clients'; and 'creating and maintaining a safe and stable residential treatment environment'. Consistent with the existing literature on trauma-informed services, our data reinforced the importance of values, such as safety, trustworthiness, collaboration, choice, and empowerment (Fallot & Harris, 2009; Harris & Fallot, 2001; Harris & Fallot, 2004). Equally, our findings endorsed the various operational principles used in trauma-informed working, such as the need to maintain a physically safe and calm therapeutic environment, provide workers with in-depth education and training about trauma, and ensure that staff have on-going support from trauma-informed supervisors (Bateman, Henderson & Kezelman, 2013; Brown, Harris & Fallot, 2013; Elliott et al., 2005; Fallot & Harris, 2009; Harris & Fallot, 2004; Herman, 1992).

Crucially, we also found that some of the most important issues underpinning the successful delivery of trauma-informed working related to staffing. Thus, staff required appropriate experience, training, and support. Equally, they needed to set boundaries, establish caring therapeutic relationships with clients, support them unconditionally, and proactively work to ensure that the treatment environment felt safe. To this end, staff were encouraged to adopt a non-judgmental approach, not give up on clients, understand client motivations and lack of motivations, treat clients with respect, provide them with round the clock support, be flexible, be caring, and firmly believe that recovery was possible for everyone. Ideally, they should even have been in recovery themselves. This placed heavy demands on those working in this intensive treatment setting.

Indeed, for staff (providing) and clients (receiving) trauma-informed treatment, the challenges seemed far-reaching. The delivery of trauma-informed residential rehabilitation treatment appeared to be replete with difficulties and tensions. These included unfilled posts, with a consequent reliance on temporary relief workers; the lack of routine staff training in trauma-informed working; and staff becoming over-protective of clients. Meanwhile, the complex and multi-faceted nature of clients' lives and problems (particularly their difficulties establishing trusting relationships and talking about their feelings, low motivation for treatment, propensity to be unsettled, difficulties regulating emotions, and concerns about safety) seemed to impede their receptivity to the trauma-informed treatment approach. This was compounded by the demanding nature of the treatment, close living arrangements, disputes between clients within the service, and distracting relationships with men outside.

Some research has already identified the stresses of working with addiction clients who have a history of trauma (Bride, Hatche & Humble, 2009; Bride & Kinztle, 2011; Ewer et al., 2015; Najavits et al., 2010), and our analyses add to that literature. In so doing, our findings have potential implications for those considering trauma informed working. In particular, there seems to be a need for financial resources to pay, train, support, and retain staff – especially if care is to be available to clients twenty-four hours a day. Further, it seems important to invest in suitable premises and facilities that enable women to feel comfortable and secure and to establish daily routines and structures that promote client safety and stability. Additionally, as there is no history of trauma-informed working in the UK or in many other countries, those wishing to develop trauma-informed services may, at least initially, need to invest in training from experienced practitioners and providers working in other organisations or even internationally. Moreover, training should ideally be provided to staff before they start working within a trauma-informed service.

Lastly, our data have indicated that both client needs and the demands of trauma-informed treatment are great. This has implications for the evaluation of trauma-informed residential

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rehabilitation services. Specifically, it seems inappropriate for services to be judged by blunt outcome measures such as numbers of clients completing treatment or achieving abstinence at predefined time points. Expectations of 'whole person recovery' (HM Government, 2010) are likely to be unrealistic after a single short episode of treatment following a long life history of trauma and abuse. It may therefore be better to aim for modest positive changes in clients' life circumstances, improved psychosocial functioning, and increased wellbeing and stability. This does not mean to say that 'full recovery' is not possible or should not be an aspiration for those with co-occurring substance use disorders and trauma. Rather, it is not the only, or necessarily the optimal, measure for evaluating trauma-informed working.

#### Study limitations and strengths

Our study focused on a single residential treatment service within the UK. Importantly, women in this service had been screened for trauma prior to treatment entry. As such, they will not necessarily have had the same characteristics as women accessing other treatment services and our findings cannot be generalised to all treatment settings. Furthermore, nearly all participants were White British and under 45 years old. This suggests that our data might not fully capture the views and experiences of women from different ethnic groups or older age groups. In addition, our study was qualitative and exploratory, focusing on how treatment was delivered and received. Thus, we did not seek to evaluate the effectiveness of trauma-informed working in the UK, although this seems to be an important topic for future research.

Despite these limitations, we obtained detailed insights into trauma-informed working from a range of individuals. This included current and former staff from the trauma-informed service and staff from the wider organisation as well as current and former clients (both those who had completed treatment successfully and those who had left treatment prematurely). This ensured that our analyses captured diverse views of treatment. To the best of our knowledge, we provide the first in-depth study of how a trauma-informed residential service

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is being delivered in practice and the first qualitative study of trauma-informed treatment in UK addiction services. These findings seem timely given that international interest in trauma-informed approaches within addiction policy and services is increasing (Covington, 2015; Killeen, Back & Brady, 2015; Mills, 2015).

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## **CONFLICT OF INTEREST**

None

## **ACKNOWLEDGMENTS**

We would like to thank the service where the research was conducted, in particular, the female staff and clients who were interviewed. We would also like to acknowledge the Pilgrim Trust for funding the study, Professor John Strang as PI for the broader work programme, and Dr Caral Brown for conducting some of the interviews. Joanne Neale is part-funded by the National Institute for Health Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King's College London. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, the Department of Health or the Pilgrim Trust.

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